

# Administrative Simplification and Health Reform

---

Presentation to the HIT Policy and  
Standards Committees  
By the Sub-Committee on Standards,  
National Committee on Vital and  
Health Statistics (NCVHS)

---

Walter Suarez, MD, MPH  
Judith Warren, PhD, RN  
Co-Chairs, Sub-Committee on Standards  
NCVHS

December 7 and 14, 2011

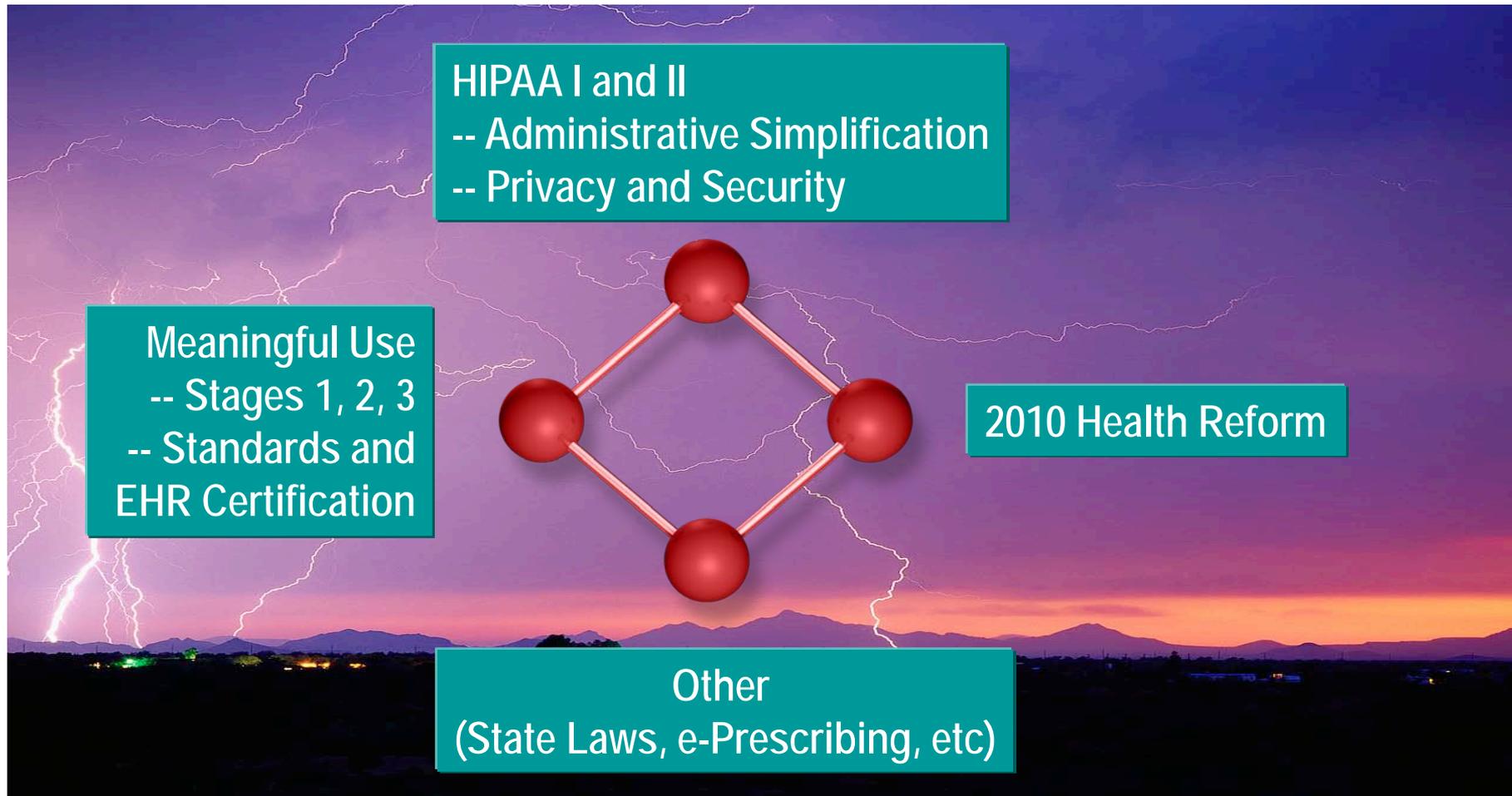


A decorative graphic consisting of several curved, overlapping lines in shades of blue and grey, extending from the left side of the slide.

## Outline

- The role of the NCVHS and the Sub-Committee on Standards
- The 2010 Affordable Care Act - Administrative Simplification Provisions
  - Section 10109
  - Claim Attachments
- Opportunities for collaboration between NCVHS and the HIT Policy and Standards Committees
- Sub-Committee on Standards 2011-2012 Work plan

## The "Persistent Storm" for Standards



- Statutory advisory committee (FACA) with responsibility for providing recommendations on health information policy and standards to the Secretary of the Department of Health and Human Services (HHS)
- Created 60 years ago to serve as advisory body to HHS on health data, statistics and national health information policy
- Composed of 18 individuals with broad expertise in the fields of health statistics, electronic interchange of health information, privacy and security, population health/public health, purchasing, financing and delivery of health care services, electronic health record systems, health services research, health data standards, and consumer interests in health information
- Organized into four Sub-Committees: Population Health; Privacy, Confidentiality and Security; Quality; and Standards

A decorative graphic on the left side of the slide consists of several overlapping, wavy lines in shades of blue and grey, curving upwards from the bottom left towards the top right.

## About NCVHS

- New responsibilities under HIPAA Law (1996)
  - Committee has legislative responsibility for making recommendations related to all aspects of HIPAA Administrative Simplification provisions (transactions, code sets, identifiers, security, privacy, etc)
- Expanded responsibilities under the 2010 Affordable Care Act to:
  - Section 1104 - define and recommend:
    - Standard for Health Plan ID
    - Operating Rules for ALL regulated transactions
    - Standards and operating rules for new transactions
    - Standards, implementation specifications and operating rules for Claim Attachments
  - Section 10109 – Provide input on new areas for standardization
  - Periodically (every 2 years) monitor status of standards and operating rules, and recommend, if necessary, changes to them (i.e., new versions)

A decorative graphic on the left side of the slide, consisting of several curved, overlapping lines in shades of blue and grey.

## NCVHS Sub-Committee on Standards

- Monitor and make recommendations on health data standards, including implementation of the Administrative Simplification provisions of Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare Modernization and Improvement Act of 2006 (MMA), Affordable Care Act (ACA), and associated subjects such as the development of a nationwide health information network (NHIN)
- Primary responsibilities include:
  1. Identify, review and recommend standards, implementation specifications and operating rules related to electronic administrative transactions, terminologies and code sets, identifiers, security measures;
  2. Monitor implementation of standards and recommend adjustments or changes, as appropriate;
  3. Review standards development process and recommend improvements when needed;
  4. Identify and review new areas for standardization
  5. Deliver an Annual HIPAA Report to Congress
  6. Work with other NCVHS sub-committees on cross-cutting issues



# The National Committee on Vital and Health Statistics

The Public Advisory Body to the Secretary of Health and Human Services

	2011	2012	2013	2014	2015	2016
<b>HIPAA TRANSACTION CODE SETS</b>						
5010, d.0, 3.0		Jan. 1 Compliance Data				
ICD-10			Oct 1: Compliance Date			
<b>ACA 1104 - UNIQUE IDENTIFIERS</b>						
Unique Health Plan Identifier		NPRM(Q1?) Oct 1: Effective date				
<b>ACA 1104 - OPERATING RULES</b>						
Eligibility and Claim Status	July 1: Adopt Operating Rules		Jan 1: Effective Date			
EFT and Claim Payment/Remittance Advice		July 1: Adopt Operating Rules		Jan 1: Effective Date		
Health claim / encounter; plan enrollment/disenrollment plan premium payment; referral cert./authorization				July 1: Adopt Operating Rules		Jan 1: Effective Date
<b>ACA 1104- NEW TRANSACTIONS/STANDARDS</b>						
EFT Standard		Jan 1: Final Rule		Jan 1: Effective Date		
Acknowledgment Standards ORs		NPRM(?)		Effective Date (?)		
Claim Attachment Standard AND Operating Rules				Jan 1: Final Rule		Jan 1: Effective Date
<b>ACA 1104 - HEALTH PLAN ADMINISTRATIVE REQUIREMENTS</b>						
Health Plan Certification for EFT, Eligibility, Claim Status and Claim Payment / Remittance Advice			Dec 31: File Certification Statement			
Health Plan Certification for health claim / encounter, plan enrollment/disenrollment, plan premium payment, referral cert / authorization AND health claim attachments					Dec 31: File Certification Statement	



# The National Committee on Vital and Health Statistics

The Public Advisory Body to the Secretary of Health and Human Services



## ACA – Section 10109

	2011	2012	2013	2014	2015	2016
<b>ACA 1109 PROVISIONS</b>						
Review Committee (can be NCVHS)				April 1: hearing (biennially) July 1: Report (Biennially)		
Input from NCVHS, HIT Policy and Standards Committees, SDOs		Jan 1: Solicit Input on additional transaction standards, operating rules, other items				

## ACA – Section 10109

- *By January 2012: Secretary to solicit input from NCVHS, HIT Standards and Policy Committees, and standard setting organizations and stakeholders on:*

*“(i).....whether there could be **greater uniformity** in financial and administrative activities and items, and  
(ii) whether such activities should be considered financial and administrative transactions **for which the adoption of standards and operating rules** would improve the operation of the health care system and reduce administrative costs.”*



## ACA – Section 10109

SPECIFICALLY, the Secretary is to seek the input of NCVHS, the HIT Policy and Standards Committees and SDOs on the following issues:

- The application process for enrollment of health care providers
- Whether the HIPAA standards and operating rules should apply to automobile insurance, worker's compensation, and other property and casualty insurance programs
- Whether standardized forms could apply to financial audits required by health plans, Federal and State agencies, and other relevant entities.
- Whether there could be greater transparency and consistency of methods used to establish health plan claim edits
- Whether health plans should be required to publish timeliness of payment rules



On November 17-18, 2011, the Sub-Committee on Standards held hearings on these topics.

## Enrollment of Providers in Health Plans

**Current State:** Providers must enroll with each health plan using proprietary processes.

**Questions:** Can industry move to a uniform application form? Can the process be made electronic and standardized?

### What we heard:

- ✓ The application process for enrollment of health care providers is unique for each and every health plan
- ✓ Reasons vary and include participation in health plan, EDI enrollment, EFT enrollment, provider directories, electronic service information discovery
- ✓ The application process is cumbersome, burdensome, repetitive
- ✓ Enrollment systems are not shared between entities; every provider has to enroll separately with every health plan; much of the information collected is identical
- ✓ Enrollment process is separate but related to provider credentialing
- ✓ Industry has some tools/sources to assist - i.e. NPI, Universal Provider Data (CAQH)
- ✓ Consider developing a general framework for enrollment (including defining scope)
- ✓ Consider establishing a multi-stakeholder group to develop recommendations



## Provider Enrollment – Policy and Standards Issues

Policy Considerations	Standards Consideration
Implications to health plan operations when defining a standard for provider enrollment (right role for standards, operating rules)	Is there an existing standard that can be used and/or modified?
Enrollment and credentialing connections	Can a provider enrollment data base be credentialed and mandated for use?
Funding issues for plans, providers and data base maintainer(s)	
Relationship to other areas, such as credentialing, provider directories	

## Should HIPAA Apply to Other Programs/Insurance?

**Current State:** HIPAA specifically carves out automobile insurance, worker's compensation, and property & casualty insurance programs

**Question:** Should the standards and operating rules apply to this industry?

**What we heard:**

- ✓ "not at this time."
- ✓ Important differences between P&C, Workers' Comp and health insurance; different terms, laws, workflows, relationships
- ✓ Key is the ability to continue immediate flow of medical information to process and pay claims
- ✓ Having the privacy rule apply to this industry would be devastating to the beneficiaries if medical records could not be shared timely
- ✓ Significant policy issues with Medicare Secondary Payer requirements
- ✓ eBilling initiative is having some success for P&C industry
- ✓ Consider supporting eBilling, voluntary use of national standards
- ✓ Consider establishing a multi-stakeholder policy advisory group to develop recommendations





## HIPAA and Other Programs – Policy and Standards

Policy Considerations	Standards Consideration
Exemption under the Privacy Rule to safeguard accessibility of medical information to assure expedited payment	E-billing (uses modified version of the ASC X12 standard)
Impact of state laws on property & casualty industry and ability to mandate consistency	



## Claim Edit Consistency

**Current state:** Claim edits are unique to every health plan

**Question:** Can there be greater transparency and consistency of methods used to establish health plan claim edits?



### What we heard:

- ✓ Providers are interested in Medicare's "National Correct Coding Initiative" (NCCI) which is proprietary to CMS
- ✓ Health plans provided caveats about using the NCCI as a foundation for a consolidated effort
- ✓ A few states (e.g. Colorado) are working on efforts to standardized claim edits across state
- ✓ Providers frustrated with inconsistency in edits because managing each unique set of edits eliminates efficiencies and is expensive: estimate 10-14% of practice revenue for managing the claims and claim edit processes
- ✓ Recommended elimination of unpublished and non-standard coding edits
- ✓ Establish nationally recognized group to develop a transparent and credible process, recommendations on standard edits, establish criteria and definitions from recognized sources



## Claim Edits – Policy and Standards Issues

Policy Considerations	Standards Consideration
Transparency between government payer efforts , private sector health plans and providers	Adopt CPT coding conventions under HIPAA
CPT guidelines for coding not adopted under HIPAA, therefore coding and edits are inconsistently applied and subject to wide deviations in interpretation – policy change possible?	Adopt Correct Coding Initiative (CCI) edit pairs as required methodology for all covered entities

## Financial Audits and Standard Forms

**Current State:** audits of providers and plans are unique and burdensome

**Questions:** Are there ways to standardize aspects of current audit activities? Can standardized forms apply to financial audits required by health plans, Federal and State agencies, and other relevant entities?

**What we heard:**

- ✓ Providers are subject to audits from Medicare, Medicaid, private plans, other entities with different requests, requirements and time frames.
- ✓ Significant administrative burden from redundant requests, lack of transparency & costs of copying





## Financial Audits – Policy and Standards Issues

Policy Considerations	Standards Consideration
Impact on fraud and abuse	NCPDP has data elements in pharmacy transactions

A decorative graphic consisting of several overlapping, wavy lines in shades of blue and grey, extending from the left side of the slide.

## ACA Section 10109 – Other Observations

### *Overall and general observations from the hearings:*

- ✓ Though there seems to be interest in addressing the topics of Section 10109, there is a sense that any substantive effort may be premature or at least awkward timing because of other pressures and priorities
- ✓ Certain topics could be identified for future study and analysis, but funding would be required to do an adequate service to any such project.
- ✓ Some of the work at CMS, including efforts by Medicare and Medicaid in the areas of claim edits and audits, are a source of frustration due to the lack of perceived transparency and industry participation.

A decorative graphic consisting of several curved, overlapping lines in shades of blue and grey, positioned to the left of the 'Claim Attachments' header.

## Claim Attachments

**Current State:** HHS proposed adoption of a suite of standards for the electronic health care claim attachment in 2005; final rule never published

**Question:** HHS needs to publish final rule defining standards, operating rules for claim attachments by no later than January, 2014; compliance no later than January, 2016

### What we heard:

- ✓ Industry uses a variety of claims attachments today; mostly manual/paper submission; expensive and time consuming for all parties
- ✓ Not everything needed as attachments comes from EHRs; not everything in EHRs currently in structured form
- ✓ Pilots of electronic attachments demonstrate significant return on investment (ROI)
- ✓ Strong support for adopting national standard combining X12 standard ("wrapper") and HL7 CDA standard
- ✓ Need to move incrementally, from paper to electronic unstructured to electronic structured messaging, and from human variant to computer variant
- ✓ Significant value in establishing consistent, predictable 'unsolicited' attachment rules for certain transactions
- ✓ No reason to wait... can start using sooner than January, 2016
- ✓ Concern regarding potential 'abuse' in the number of requests for attachments; goal is to reduce number
- ✓ There is a set of consistent priority areas for applicability of attachments
- ✓ Need to identify/name operating rules authoring entity now



## Claim Attachments – Policy and Standards Issues

Policy Considerations	Standards Consideration
Discern how electronic claim attachments apply to efforts for electronic medical records	What standards are available for consideration? X12, HL7?
Consider leveraging Medicare initiatives such as eSMD	Provider signature and authentication options
How can volume and type of requests for attachments be reduced?	
Funding barriers to pilot and implement voluntarily	

A decorative graphic on the left side of the slide, consisting of several overlapping, wavy lines in shades of blue and grey, curving upwards from the bottom left towards the top right.

## Opportunities for Collaboration

- In Section 10109, the Affordable Care Act enjoins the Secretary to seek input from NCVHS, the HIT Standards and Policy Committees, standards development organizations and stakeholders
- Through its recent work and hearings, NCVHS has taken initial steps to address these needs
- NCVHS can work with both Committees to
  - Identify policy recommendations, based on findings from hearings
  - Identify possible standards recommendations
  - Identify additional areas for standardization, beyond those mentioned in the ACA
- Next Steps
  - Draft letters of Observations and Recommendations (January 2012)
  - Distribute to HIT Committees for input (January-February, 2012)
  - Submit to Secretary (February, 2012)



**The National Committee on Vital and Health Statistics**  
*The Public Advisory Body to the Secretary of Health and Human Services*



**NCVHS Sub-Committee on  
Standards  
Activity Agenda  
2011 - 2012**



## 2011 Activities

### Letters on EFT/ERA

- Recommendation on EFT Standard
- Recommendation on Operating Rules Authoring Entity
- Recommendations on Operating Rules (ORs)

February 2011



March 2011



Sept 2011



Hearing on Acknowledgments, ORs Process

April, 2011



DSMO Report to NCVHS

June 2011



Hearing on Status of 5010/ICD-10 Implementation

June, 2011



Tenth HIPAA Report to Congress

Sept 2011



Hearing on Section 10109 (Next Areas for Standardization)

Nov, 2011



Hearing on Claim Attachments – Part 1

Nov, 2011



(Overview, Status of Standards, Directions)

Hearing on Standards and ORs Maintenance Process

Nov, 2011



## **Sub-committee on Standards**

- The Agenda Forward (2012 and beyond)
  - Continue work on Administrative Simplification (HIPAA, ACA)
  - Review new areas for standardization (ACA Section 10109)
    - Provider enrollment in health plans, applicability of standards and operating rules to workers' comp., auto insurance; standardization of claim edits; etc
  - New areas for standardization, beyond Section 10109
    - First Report of Injury (original HIPAA transaction); electronic signature standards; metadata standards; e-consent standards; personal health record standards (messaging, content, privacy and security); standards for APCDs;
  - Continue review and improvement of standards and operating rules maintenance process

## **Sub-committee on Standards**

- **The Agenda Forward (2012 and beyond)**
  - **Public Health Data Standards**
    - Bi-directional exchange of information between public health, clinical care, health plans and others
    - National/International standard for public health messaging/reports (including vital records, acute disease reporting, chronic conditions reports, disease-specific reporting, event-specific reporting, other); activities being done by PHDSC, HL7, ISO, IHE, S&I Framework and others
  - **Public Health Information Technology Architecture reference model**
    - Enterprise architecture model for public health; health information model applicable to public health; health terminology model used by public health
  - **Public Health Reference Information Model**
    - Identifying and adopting and national reference information model for public health
  - **Other Areas**
    - Data standards related to health disparities
    - Other

## **Sub-committee on Standards**

### Planned Activities for 2012

- Industry status of initial implementation of 5010, D.O, 3.0
- Industry status on the transition to ICD-10
- Preparation for Health Plan ID, Operating Rules for Eligibility, Claim Status
- 2012 DSMO Report
- Eleventh HIPAA Report to Congress
- Continue review and improvement of standards and ORs maintenance process
- Identification/Recommendation on Authoring Entity/Entities for Operating Rules for Claim, Enrollment, Premium Payment, Referral Authorization
- Public Health Data Standards, IT Architecture, Reference Information Model
- Claim Attachment Standards and Operating Rules (late 2012/early 2013)
- New areas for standardization, beyond Section 10109
  - First Report of Injury (original HIPAA transaction); electronic signature standards; metadata standards; e-consent standards; personal health record standards (messaging, content, privacy and security); standards for APCDs
  - Standards associated with socioeconomic and demographics and health disparities